

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General	Employer (Name & Address incl. zip)				Carrier/Administrator Claim Number		Report Purpose Code					
					Jurisdiction		Jurisdiction Claim No.					
	Insured Report No.											
	Employer's Location Address (if different)						Location No.					
NAICS Code				Employer FEIN				Phone No.				
Carrier/Claims Admin	Carrier (Name, Address & Phone Number)				Policy Period		Claims Admin (Name, Address & Phone Number)					
					To							
	<input type="checkbox"/>		Check if self insured									
Carrier FEIN				Policy Number or Self-Insured Number				Administrator FEIN				
Agent Name & Code Number												
Employee	Legal Name (Last, First, Middle)			Birth Date		Social Security Number			Date Hired		State of Hire	
	Address (Incl. Zip)			Sex		Marital Status			Occupation/Job Title			
				<input type="checkbox"/> Male		<input type="checkbox"/> Unmarried/Single/Div.						
				<input type="checkbox"/> Female		<input type="checkbox"/> Married						
	Phone			<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated			Employment Status			
				No. of Dependents		<input type="checkbox"/> Unknown			NCCI Class Code			
Wage Rate		<input type="checkbox"/> Day		<input type="checkbox"/> Month		# Days Worked/WK		Full Pay for Date of Injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
\$		<input type="checkbox"/> Week		<input type="checkbox"/> Other		# Hrs Worked per Day		Did Salary Continue?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Time Employee Began Work		<input type="checkbox"/> AM <input type="checkbox"/> PM		Date of Injury or Illness		Time Occurred		<input type="checkbox"/> AM <input type="checkbox"/> PM		Last Work Date		
										Date Employer Notified		
										Date Disability Began		
Employer Contact Name/Phone Number						Type of Illness/Injury			Part of Body Affected			
Did Injury/Illness Exposure Occur on Employer's Premises?				Yes <input type="checkbox"/> No <input type="checkbox"/>		Type of Illness/Injury Code			Part of Body Affected Code			
Department or location where accident or illness exposure occurred						All Equipment, Materials, or Chemicals Employee Using upon Occurrence						
Specific Activity Employee Engaged in at Time of Occurrence						Work Process the Employee Was Engaged in at Time of Occurrence						
How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill.										Cause of Injury Code		
Date Returned to Work				If Fatal, Date of Death				Were Safeguards or Safety Equipment Provided?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
								Were they used?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Treatment	Physician/Health Care Provider (Name & Address)				Hospital (Name & Address)				Initial Treatment			
									0 <input type="checkbox"/> No Medical Treatment 1 <input type="checkbox"/> Minor: By Employer 2 <input type="checkbox"/> Minor Clinic/Hosp 3 <input type="checkbox"/> Emergency Care 4 <input type="checkbox"/> Hospitalized – 24 hr. 5 <input type="checkbox"/> Anticipated Major Med/Lost Time			
Other	Signature of Injured Employee, or Signature on File, Date				Witness to Accident (Name & Phone Number)							
	Date Administrator Notified				Date Prepared		Preparer's Name & Title		Preparer's Phone Number			

Filing this report is not an admission of liability. This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made. Idaho Industrial Commission, P.O. Box 83720, Boise, ID 83720-0041 IC Form IA-1 (08/2013)